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Opportunities to Address Common Concerns: A National Study of Single Point of Entry

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Introduction

Publicly funded human service systems are grappling with how to help those in need of supports and are seeking ways to overcome barriers that limit chances for success. The last ten years have seen a growing demand for change in the delivery of human services. The operative words have become system change, cooperation, coordination, collaboration and integration. Many state officials are recognizing that state services scattered among multiple agencies and programs often result in confusion and inefficiency. Most human service organizations are organized around a functional specialty such as income support, mental health or developmental disabilities and have developed their own guidelines for deciding who is eligible for services. Many families and individuals with developmental disabilities receive assistance from more than one department, yet there is no integration of services between agencies. Each agency has its own intake and eligibility process, referral mechanisms, assessment tools and placement procedures. Families often have difficulty even finding the correct "front door" to the department they need to contact. Families become frustrated, isolated, and disheartened.

Recognizing these concerns, the Governor's Commission on Mental Retardation Task Force on Innovation conducted a study, which examined the concept of a single point of entry (SEP), as one component of an integrated long-term care system. This report will describe the development of the study and its results, relevant findings in research, and strategies for improving access.

Overview

The interest in reforming the categorical services system is not a new concept. For many years state and local organizations, some with federal encouragement, have experimented with new forms of organization and new service delivery strategies to counter fragmentation and improve access. The settlement house movement at the turn of the century was an attempt to bring together a wide range of services needed by the poor in a neighborhood location. The problems of the system intensified and policy makers responded with the best of motivations. Unfortunately, the social programs initiated in the 1960s and 1970s to address urgent and specific social problems in fact increased categorization, and the complex eligibility rules and program regulations prevented states and communities from using the funding and programs flexibly. In 1979, the office of Human Development Services in the Department of Health and Human Services (DHHS) funded the National Network for Coordinating Human Services to develop and maintain linkages between individuals and organizations interested in coordinating services that cross categorical boundaries, government jurisdictions, and public and private services. Special attention was focused on creating a common intake and eligibility process, however, the budget cuts of the 1980s curtailed many of these reform efforts. (Preister, 1996). In the 1990s, many states have launched initiatives to revamp and revitalize the way in which citizens interact with state government and access the various services and programs.

An examination of the concept of a single point of entry requires an understanding of how the human service delivery system is organized in Massachusetts. The Executive Office of Health and Human Services (EOHHS) is a secretariat, with an aggregate expenditure level exceeding $8 billion. EOHHS oversees 15 departments who provide services to approximately one million consumers. Currently, more than 30% of EOHHS consumers receive services from more than one agency. However, there is little standardized or consistent information sharing among agencies. As a result, clients often receive services that are fragmented and fail to respond in a comprehensive manner (Executive Summary, EOHHS Integrated Technology, 1999). It is not uncommon for "at-risk" families with several children to have between 4-8 workers assigned to them from different agencies—the child protective services worker, the visiting nurse, the drug abuse counselor, the health care worker, and the social security representative. Each one of these is only concerned with a segment of what they see as a dysfunctional family. The workers seldom communicate with each other and none of them have the responsibility to assess the family's needs or strengths or work with the family's well being as a whole. Typically, a family in need of interagency supports will have to go to several different offices to establish eligibility for services, and they will have to do this several times, filling out different forms each time. Each program has different definitions of who qualifies for assistance and rules about how to count and document income and assets. In addition, families with children with multiple needs confront rules governing funding that are often restrictive and contradictory depending upon an agencies' polices or procedures.

Table 1

Massachusetts Executive Office of Health and Human Services

Governor
Lt. Governor

Executive Office of Health and Human Services

- Division of Health Care Finance and Policy
- Division of Medical Assistance
- Department of Mental Health
- Department of Mental Retardation
- Department of Public Health
- Massachusetts Office for Refugees and Immigrants
- Massachusetts Rehabilitation Commission
- Office of Child Care Services
- Department of Social Services
- Department of Transitional Assistance
- Department of Youth Services
- Massachusetts Commission for the Blind
- Massachusetts Commission for the Deaf and Hard of Hearing
- Soldier's Home - Chelsea
- Soldier's Home - Holyoke

Despite the best of intentions, the basic design and organization of the human services system is particularly difficult for individuals and their families who have multiple needs. There is a growing consensus that the system needs to be reformed. The challenge facing Massachusetts and other states is to develop systems to support the delivery of services and respond to the needs of consumers and their families by better coordinating and integrating services. Increased agency coordination and cooperation, coupled with seamless integration of information, will result in improvements in the way citizens gain access to services.

Definitions of Terms

A *single point of entry* is the "one-stop" shop where consumers obtain access to long-term care services. It is a method, which may simplify access to services, because it provides a local or regional access point where consumers receive information and assistance, assessment of needs, care planning and authorization of services (Hawaii Senate Resolution, 1995). Consumers would have an easier, quicker and simpler way to become aware of the range of services available to them. Ideally, individuals and their families would be able to go through a single portal to learn of the entire spectrum of programs and services. A single point of entry is merely the funnel through which consumers pass in order to obtain end services. This mechanism will allow for a "single client view" necessary for comprehensive case planning, improvements in the consistency and accuracy of data and the elimination of duplicative data entry (Pan, 1995). The primary reason for a single point of entry is to provide consumers with a consistent intake experience and appropriate program information and referral regardless of the initial site they use to access the system.

Only one Door?

A local or regional single point of entry providing centralized access may make access easier. However, centralized access does not mean the use of only one site or the use of sites located only in centralized areas. Routing everyone this way would create unnecessary bottlenecks and may actually reduce ease of entry. More than one site is needed, including access points located in remote areas. *Centralized access means access through a centralized system.*

(Justice, 1988)

Other terms such as *central point of entry*, *central access point* or *shared front-end* are commonly used throughout the literature. Regardless of the nomenclature, the single point of entry component of an integrated long-term care system reduces fragmentation by centralizing access, assessing and screening consumers in a uniform manner and directing individuals to the appropriate services through case management.

Purpose

Currently, people in need must choose from hundreds of points of entry to the service delivery system. They have to assess the problem, and then guess which executive office, commission, board, department, council, agency, state hospital, or area/regional office might provide the appropriate services. The first door chosen is often the wrong one. If they are lucky, someone directs them to the right door, too often however; all points of entry to our complex service system remain confusing. "Faced with this litany of barriers and problems, it is a miracle that some families do become adept at negotiating these system mazes and do manage to get the benefits and services… and use them to improve their children's and families' lives" (Ooms and Owen, 1991).

> There is a growing consensus that the *initial contact into the human service system is critical.* It increases the chances that consumers will receive advice on all the alternatives, thus enhancing the chances of appropriate assessments and provision of services.
>
> (Justice, 1998)

The current structures that exist for monitoring, implementing and providing human services were created over many decades in a piecemeal fashion. State services are scattered among multiple agencies and too often disintegration results in confusion and inefficiency. The Governor's Commission on Mental Retardation Task Force on Innovation determined that this confusion often begins with the initial contact between the family and the state. Time is often spent filling out duplicative intake, referral, assessment and eligibility forms. Families are demoralized, frustrated and weary. Recognizing these concerns, the Governor's Commission on Mental Retardation Task Force on Innovation conducted a national survey, which examined the concept of a single point of entry as a mechanism to improve the way citizens gain access and information to state services.

Methodology

In January 2001, a six-page survey instrument consisting of 30 questions was sent to the fifty-four state directors of developmental disability services and the District of Columbia. The survey was designed to collect fundamental agency information as well as topics related to program management, organizational structure, and the establishment of a single point of entry. {see Appendix 1}. In addition, states were asked to identify administrative barriers or obstacles that prevent the development of a single point of entry.

The majority of questions were designed in a closed format that required respondents to choose from response options. Three questions were open-ended, inviting written comment.

The process of obtaining, screening, and verifying states'data took place between January 2001 and March 2001. Two follow–up letters were sent to all non-respondents.

Results

A total of 55 surveys were mailed, and responses were collected from 29 states (53%). Additionally, five states indicated that they are in the preliminary stages of exploring this issue and did not have sufficient information to complete the survey at this time. The findings presented in this paper will be discussed in three major sections.

The first section provides a general profile of the respondents including:

- Numbers of Individuals with mental retardation or developmental disabilities (MR/DD) Receiving Services;
- Year of Participation in the Federal Home and Community-Based Waiver Program;
- Number of Individuals with MR/DD Receiving Federal Home and Community-Based Waiver Services;
- Waiver Expenditures for Individuals with MR/DD.

The second section will review state organizational structures, financial strategies and program management initiatives. The final section will review constructive outcomes and identify challenges and obstacles to implementation of a single point of entry.

Profile of Respondents

Individuals with MR/DD Receiving Services

States were asked to indicate the number of individuals with mental retardation and developmental disabilities receiving services as of FY'99. Twenty-nine states reported that they served a total of 895,624 individuals in FY'99. These figures include persons receiving residential, day and support services. Several states indicated that they do not report data separately for individuals with MR/DD and would combine their data in responding to the survey questions. Table 2 presents state-by-state data with respect to the numbers of individuals with MR/DD receiving services.

> On June 30, 1998, there were an estimated 372,179 people with mental retardation and related developmental disabilities receiving residential services.
>
> (Prouty, R., & Lakin, K.C. (Eds.), 1993, 1998)

Table 2

Individuals with MR/DD Receiving Services

State	Individuals with DD	Individuals with MR	Total
AR	9,000	4,000	13,000
CA	165,819	*	165,819
CO	11,109	*	11,109
CT	DNF	18,300	18,300
DE	DNF	2,355 [b]	2,355
DC	1,550	*	1,550
FL	30,436	26,115	56,551
GA	DNF	10,948	10,948
HI	2,530	*	2,530
ID	9,000	*	9,000
IL	60,000	*	60,000
KS	8,046	*	8,046
KY	DNF	2,529	2,529
ME	*	4,400	4,400
MD	17,401	DNF	17,401
MA	DNF	29,000	29,000
MI	26,435	*	26,435
NH	7,300	*	7,300
NM	6,500	6,500	13,000
NY	120,000	*	120,000
NC	30,000	*	30,000
ND	3,487 [a]	*	3,487
OH	56,079	*	56,079
OK	DNF	8,500	8,500
PA	*	77,000	77,000
SC	23,000	20,000	43,000
TX	DNF	28,657	28,657
VA	DNF	21,772	21,772
WA	30,742	17,114	47,856
TOTALS	***618,434***	***277,190***	***895,624***

(*) MR/DD Included (DNF) Data not furnished
(a) FY' 2000 data (b) FY' 2001 data

Year of Participation in the Federal Home and Community-Based Waiver Program

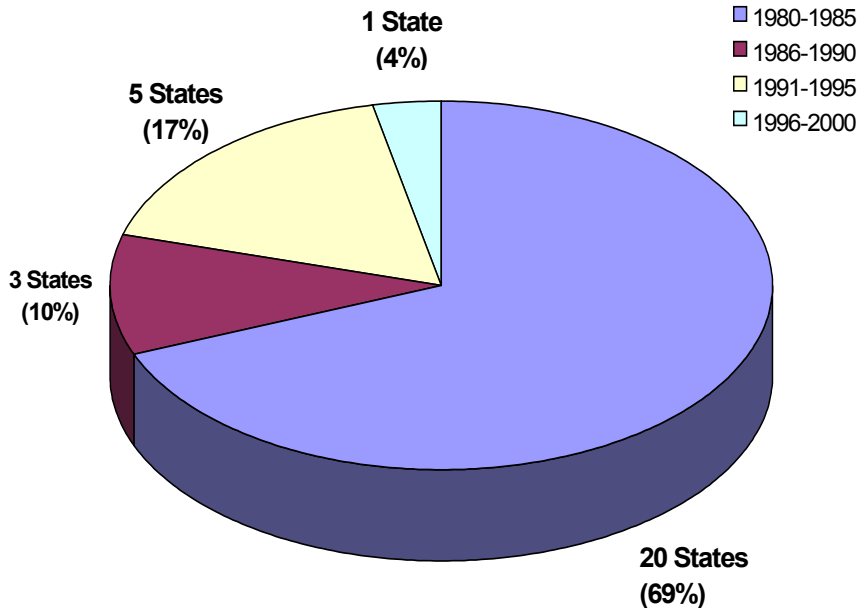
Twenty-nine (100%) states reported that they participate in the Federal Home and Community-Based Waiver program. Twenty states (69%) reported that they started participating in the Federal Home and Community-Based Waiver program in FY' 1981-1985. Three states (10%) started to utilize the Waiver program in FY' 1986-1990. Five states (17%) started to utilize the Waiver program in FY'1991-1995 and one state (4%) started to utilize the Waiver program in FY'1998. Given the federal authorization to "waive" certain requirements in 1981, it is not surprising to see the volume of participating states in the early 1980s.

The Home and Community-Based Services Waiver

Congress authorized the Home and Community-Based Waiver Program in the Omnibus Budget Reconciliation Act of 1981 (PL 97-35). The legislation was enacted in response to escalating ICF/MR costs, and the fact that Medicaid made it easier to institutionalize people with developmental disabilities rather than to provide support in community settings. The law contained provisions authorizing the states to "waive" certain statutory requirements of the Medicaid program. The HCBS Waiver authorizes federal reimbursements for a wide array of community services and supports.

Table 3

Participation in the Federal Home and Community-Based Waiver

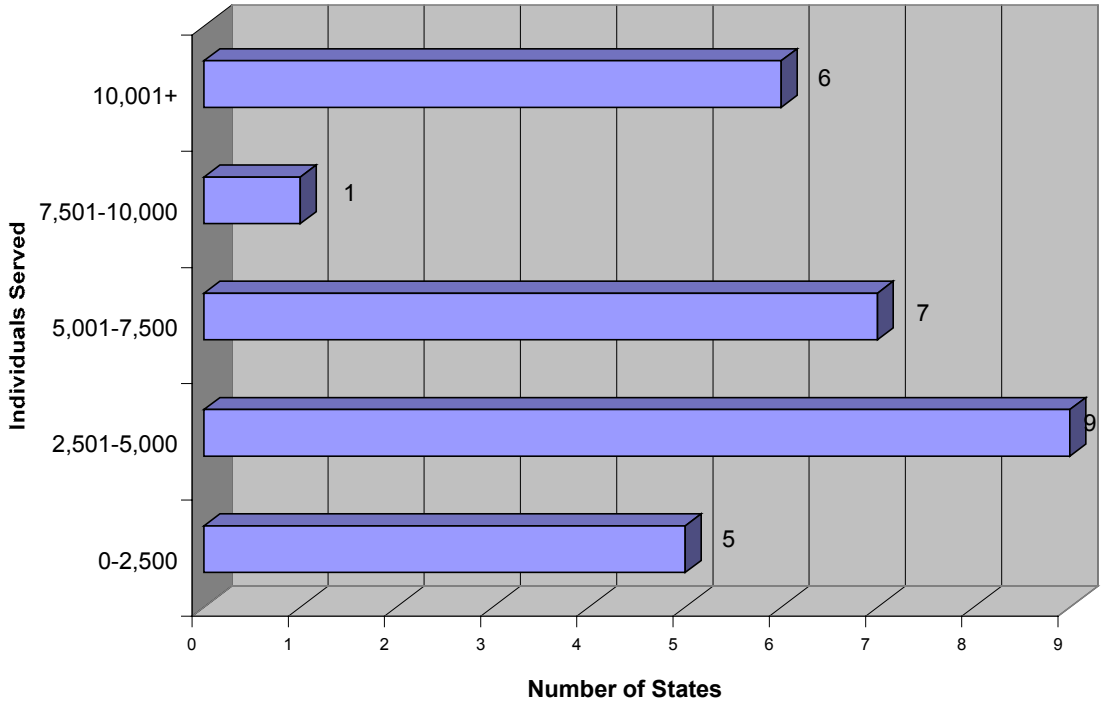


Individuals with MR/DD Receiving Home and Community-Based Waiver Services

The Home and Community-Based Waiver permits federal reimbursement for an array of community services and supports. These include habilitation training, respite care and other family supports, case management, supported employment, supported living and many other types of assistance in community environments. States were asked to indicate the number of individuals with mental retardation and developmental disabilities receiving waiver services. Twenty-eight states (97%) reported that they served a total of 236,808 individuals with mental retardation and developmental disabilities. Five states (18%) indicated that they provide services to approximately 1-2,500 individuals. Nine states (32%) indicated that they provide services to 2,500-5,000 individuals. Seven states (25%) indicated that they provide services to 5,001-7,500 individuals. One state (4%) indicated that they provide services to 7,500-10,000 individuals and six states (21%) serve more than 10,000 individuals using the federal home and community-based waiver.

Table 4

Individuals with MR/DD Receiving Waiver Services



Home and Community-Based Waiver Expenditures

The Home and Community-Based Waiver is the major source of federal funding for community services. Over the past decade, the waiver program experienced a rapid rate of growth. "The Waiver program grew from $1.2 million in federal reimbursements in 1982 to $833 million in 1992" (Braddock et al., 1995). This rapid rate of growth has continued. In 1999, twenty-seven states (93%) indicated that they receive federal reimbursements totaling $6.635 billion. One state (4%) reported that they receive $226,000 in federal reimbursement. Six states (22%) reported that they receive $1 million-$99 million in federal reimbursement. Ten states (37%) reported that they receive $100 million-$199 million in federal reimbursement. Four states (15%) reported that they receive $200 million-$299 million in federal reimbursement. One state (4%) reported that they receive $300 million-$399 million in federal reimbursement. Two states (7%) reported that they receive $400 million-$499 million in federal reimbursement and three states (11%) reported that they receive over $500 million in federal reimbursements. [See Table 5] New York State receives $1,761,181,000 and represents 25% of the total federal reimbursements reported.

Table 5

Waiver Expenditures by State

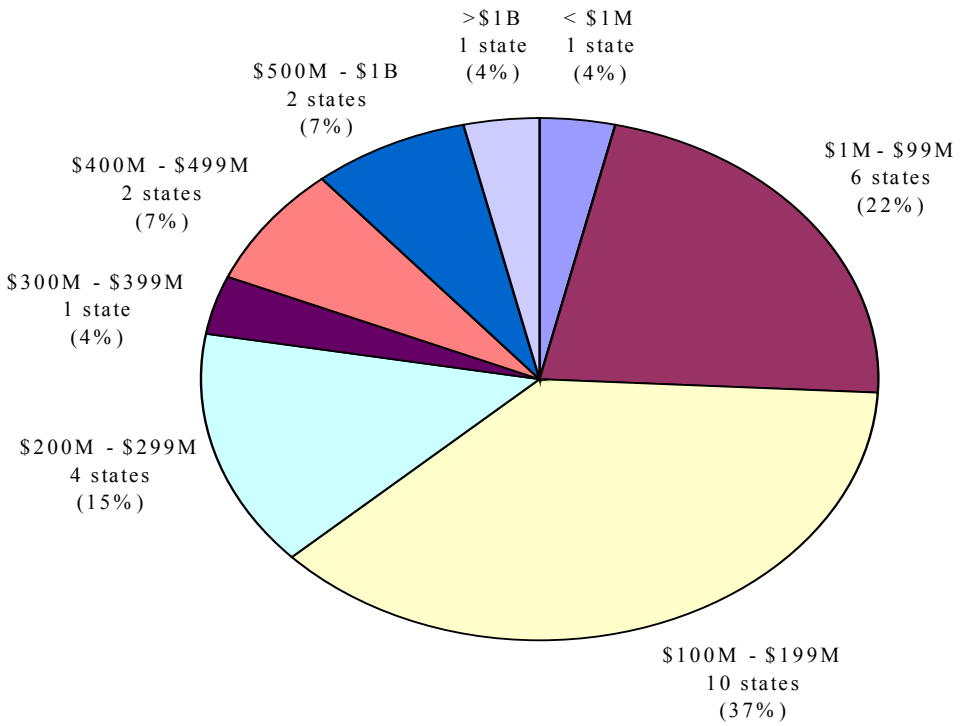


Table 6

Federal HCBS Waiver Spending: FY 1999

Rank	State	MR/DD Waiver Participants	Years in Effect	Expenditures
1	NY	38,000	8	$1,761,181,000.00
2	PA	15,337	16	$654,915,323.00
3	CA	27,959	17	$483,323,000.00
4	MA	10,375	15	$423,900,000.00
5	SC	4,319	8	$339,000,000.00
6	CT	5,390	12	$344,079,000.00
7	WA	13,971	16	$297,003,409.00
8	TX	5,289	14	$238,369,677.00
9	MI	8,736	14	$231,832,942.00 [a]
10	FL	44,701	17	$213,654,888.00
11	CO	5,817	16	$191,084,306.00
12	MD	4,328	15	$169,526,260.00
13	KS	5,120	15	$156,940,677.00
14	IL	6,961	16	$150,700,000.00
15	OK	2,639	14	$136,408,713.00
16	NC	6,081	16	$136,043,271.00
17	ME	1,900	15	$128,027,644.00
18	NH	2,565	16	$117,000,000.00
19	VA	4,896	8	$113,325,589.00
20	GA	3,302	11	$109,828,405.00
21	OH	4,977	8	$96,081,981.00
22	ND	3,872	16	$41,961,852.00
23	DE	517	16	$35,683,546.00
24	AR	2,665	10	$34,048,498.78
25	HI	800	16	$19,700,000.00
26	ID	822	5	$12,000,000.00
27	DC	69	1	$226,292.50
28	KY	-	15	*
29	NM	5,400	19	*
TOTAL		236,808		$6,635,846,274.28

(*) No Data Available (a) FY' 1998 Data

Table 6 presents data on a state-by-state basis on waiver expenditures and numbers of individuals participating in waiver–funded services. In terms of participants served, the largest waiver programs in 1999 were predictably, in populous states: New York, Pennsylvania, California, and Massachusetts.

The next section of the report will examine state organizational structures, financial strategies and program management initiatives.

State Agency Structure

In an effort to promote coordination and integration of human services, and improve access to state services, states have been experimenting with new executive branch structures to see if these can be more effective than the traditional separate, multiagency approach. Three basic models of state agency structures have emerged to manage long-term care systems for individuals with MR/DD.

Consolidation Model

The first model consolidates all long-term care responsibilities covering both institutional and community-based care into a single, sole-purpose agency. Of the twenty-eight states that responded, nine states (32%) have consolidated MR/DD services in an attempt to counter fragmentation and improve efficiency and effectiveness. (Kansas, New Hampshire, Maryland, New York, Florida, Hawaii, South Carolina, Georgia and Connecticut). Several states noted that their human service delivery systems were complex, confusing and inefficient. In 1993, *Georgia's* General Assembly initiated a sweeping reform initiative of the public mental health service system. Services and supports for individuals with mental retardation and developmental disabilities are provided through the Division of Mental Health, Mental Retardation and Substance Abuse (MHMRSA) within the Department of Human Resources. MHMRSA regional boards act as "contact points" for individuals and their families seeking these services. Their mission is to assist families in navigating the various systems of care. These regional boards are responsible for planning, coordinating, implementing and evaluating services and supports.

In 1996, *Kansas* created twenty-eight Community Developmental Disabilities Organizations (CDDO's) across the state to serve as the single point of entry into the state's system of services for persons' with developmental disabilities. Each CDDO is responsible for serving as a single point of application, eligibility determination, and referral. A uniform statewide application was designed which eliminated duplicative entrance requirements.

Maryland has established four regional offices that serve as the entry points into the service delivery system. Eligibility determination and development of a service plan is coordinated through the regional office by a resource coordinator. Services and supports for individuals with mental retardation and developmental disabilities are coordinated through the Department of Health and Mental Hygiene Developmental Disabilities Administration.

Umbrella Agency Model

The second model uses an umbrella agency structure with separate cabinet agencies reporting to a human service secretariat. Services and supports for individuals with mental retardation and other developmental disabilities are managed within the separate cabinets with oversight from the human service agency. Eleven states (39%) indicated that they currently operate under this structure. (Arizona, California, Delaware, Kentucky, Maine, Massachusetts, North Carolina, North Dakota, Texas, Virginia, Washington.)

Many states reported on the need to improve interagency coordination so that information and data can be shared across programs and departments. As a result, individuals and families will be able to access services from any point at which they enter the system.

Texas has four state agencies and thirteen state-funded long-term care programs that have a goal or outcome related to accessing services. In addition, sixteen different programs provide case management services. An analysis completed in November 2000 concluded that "access to the service system may be confusing and individuals may not know where to go for information and services" (Texas Health and Human Services Commission, 2000). The Texas legislature adopted Senate Bill 374 which mandated the establishment of an integrated local system of access and services for elderly persons and persons with disabilities. A key requirement of the new system is the development of "navigator services" to assess individual needs, connect individuals to appropriate services and resources, and follow-up to ensure the person has received needed information. In addition, the Local Mental Retardation Authority will be the single point of access and will (a) determine persons eligible for mental retardation services provided; (b) provide information about services, supports, and providers; and (c) facilitate the person-directed planning process.

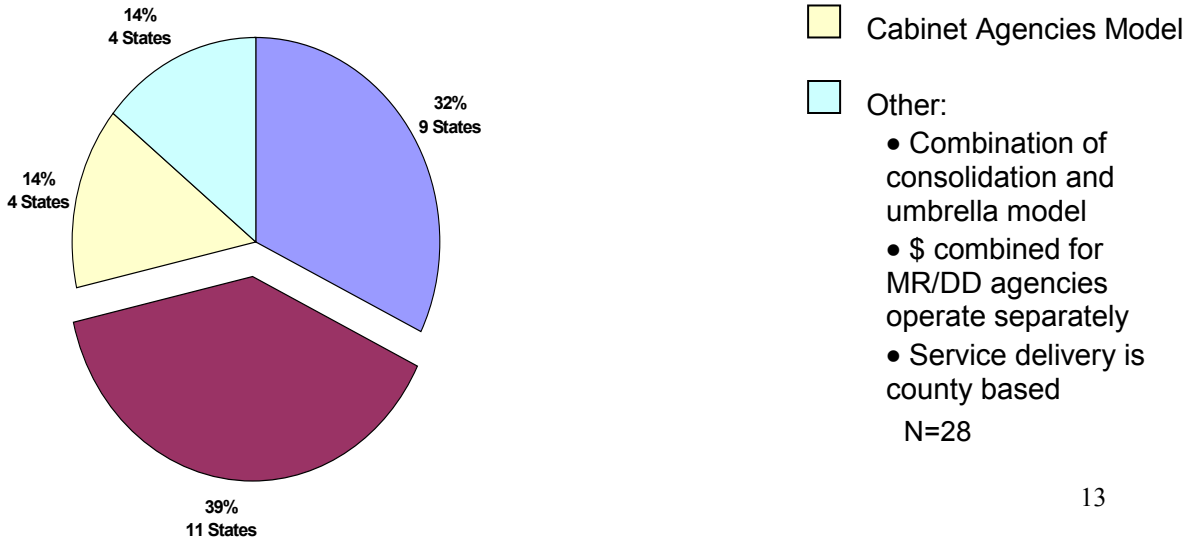
The *Arizona* Government Information Technology Agency in conjunction with Public Interest Breakthroughs of Virginia developed an initiative called "No Wrong Door." Families were often confused about how to enter the system or where to begin searching for appropriate supports. This initiative ensures that families receive appropriate services regardless of the portal they use to enter the system. The initiative integrates services from five different state agencies and fifty different policy areas.

Cabinet Agencies Model

The third model retains independent cabinet level agencies for managing various programs but establishes a direct reporting relationship with the executive branch of state government. Four states (14%) reported that they operate under this structure. (New Mexico, Ohio, Oklahoma, Pennsylvania)

Table 7

State Agency Structure



A review of state organizational structures is not complete without an examination of two states, Illinois and Michigan, who initiated a sweeping reorganization of state government agencies.

The *Illinois* Department of Human Services was created in July 1977 under the leadership of Governor Jim Edgar. " It brought together in one department a vast array of services, from welfare assistance to alcohol and substance abuse treatment to mental health and disability programs" (Becker et. al., 1998). The department serves more than 1.8 million people, employs more than 20,000 staff, and spends approximately $4 billion a year. Prior to the reorganization, seven independent departments delivered human services in Illinois. Each department had its own guidelines for deciding who was eligible to receive services, its own case management systems, and its own policies and procedures for accessing services. The new system is reorganized around core processes; intake and eligibility, service coordination and outcome management. Individuals in need of supports receive a single comprehensive screening for all matters that fall within the Department of Human Services domain.

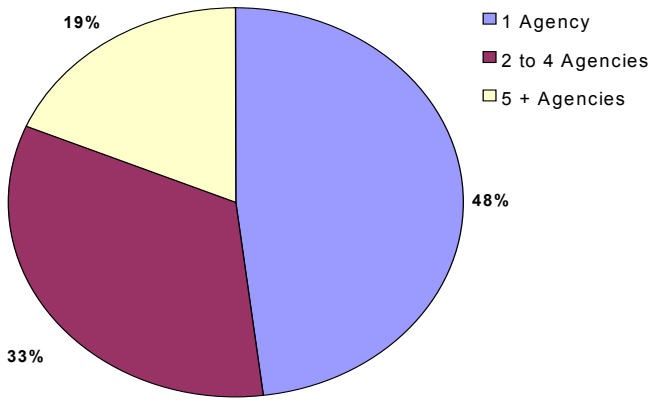
Michigan created the Department of Community Heath in 1996 by consolidating the Department of Public Health, the Department of Mental Health, the Medical Services Administration, the Office of Drug Control Policy and the Office of Services to the Aging. Services and supports for individuals with mental retardation and developmental disabilities are provided through 49 community mental health service providers (CMHSP) who contract with the state. These providers are the single point of entry for individuals and families and are able to provide comprehensive assessments, referrals and service delivery.

Number of Agencies Responsible for Service Delivery

States vary a great deal in the organizational structure of their health and human services delivery system. Twenty-seven states (93%) reported on the number of agencies that deliver supports and services to individuals with mental retardation and developmental disabilities. Thirteen states (48%) indicated that only one agency is responsible for service delivery, nine states (33%) indicated that two-four agencies are responsible for service delivery and five states (19%) indicated that five or more agencies are responsible for service delivery to individuals with MR/DD.

Table 8

Number of Agencies Responsible for Service Delivery for Individuals with MR/DD



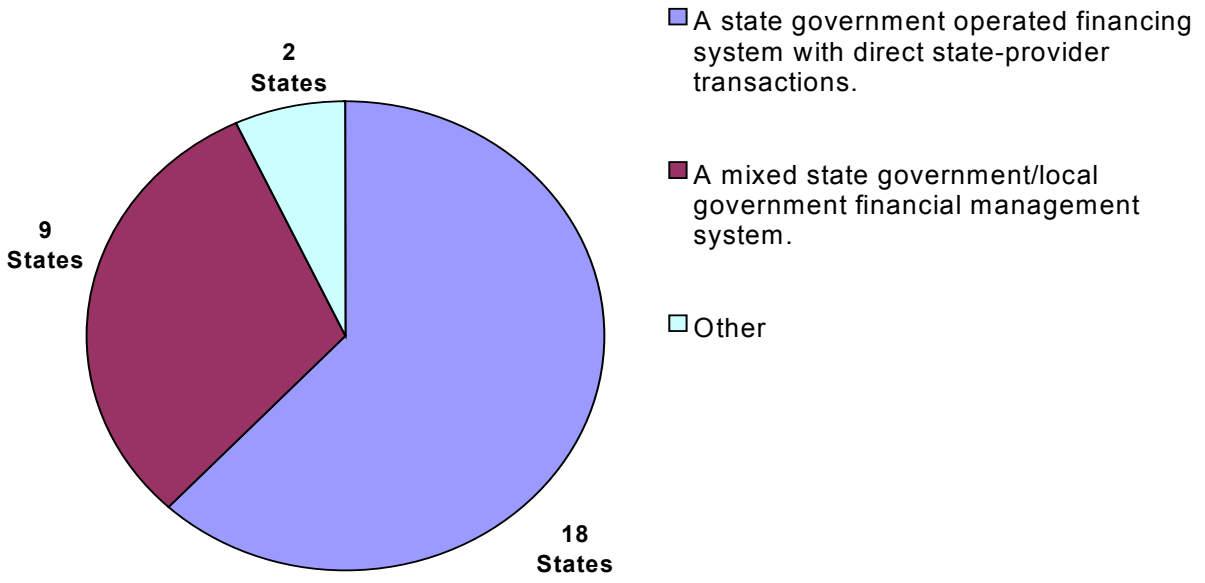
Financial Strategies

States use a combination of funding sources to support community care systems for individuals with mental retardation or developmental disabilities. Twenty-six states (90%) indicated that the three major financing sources are state general revenues, Medicaid home and community-based services waivers, and local or federal grants. Each of the respondents uses one of these mechanisms as their primary funding vehicle supplemented by one or more of the other funding sources. Twenty-two states (85%) use Medicaid financing to help support over 50% of their service delivery system.

States were also asked to report on the financial management system that regulates their financing strategy. Twenty-seven states (93%) indicated that there were two basic models of financial management arrangements. Eighteen states utilize a mixed state government/local government financial management system and nine states use a state government operated financing system with direct state-provider transactions. In addition, two states indicated that they use county-based management systems.

Table 9

State Financial Management Structure

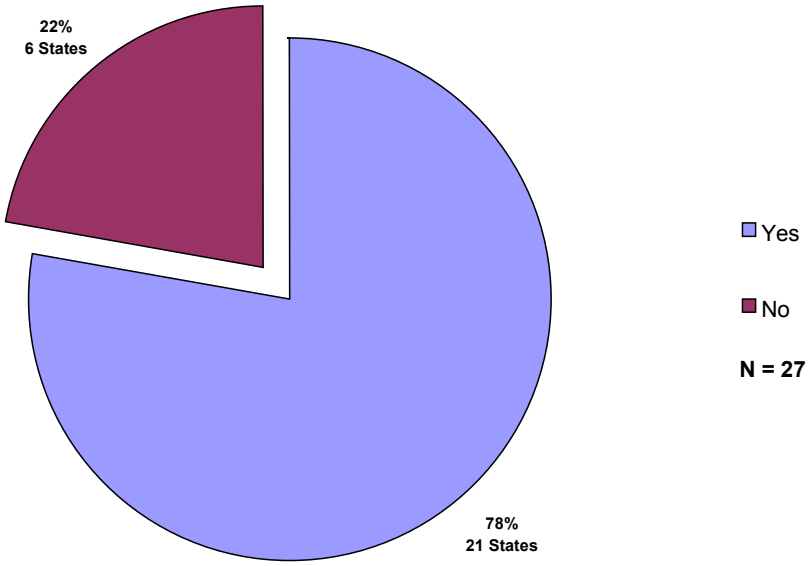


Program Management Initiatives

Currently, the myriad patchwork of uncoordinated services in the human services delivery system means that no one is "in charge" of ensuring easy access to services. Different agencies typically do not work toward common goals or develop a coordinated strategy. Each agency often sees a different piece of the problem and therefore, has different ideas about how to solve it. These solutions seldom reinforce each other and may go in quite different directions and even conflict. Often times, there is a great deal of blaming, buck passing and duplication of effort. Twenty-one (78%) states indicated that they have trouble facilitating access to interagency services and supports for individuals with mental retardation and developmental disabilities. [See Table 10]

Table 10

Interagency Planning: Is it Difficult to Facilitate Access?

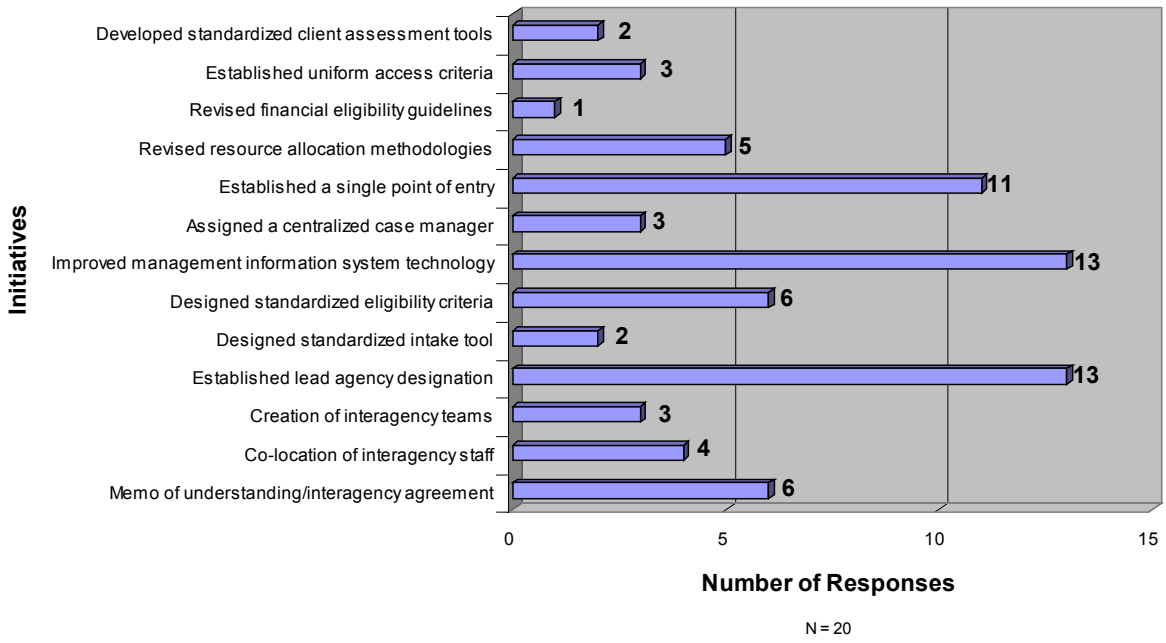


Creating a new process is not a simple task. As the Center for the Study of Social Policy postulates: "It requires rethinking the mechanisms through which states and localities have governed services in the past. It also entails negotiating new roles among service agencies and implementing more collaborative decision making among previously autonomous public and private funders and providers. Perhaps most important, it requires that states make a commitment to a continual reexamination of service operations while also adjusting and retooling them as necessary to make services more effective" (CSSP, 1991).

Twenty out of twenty-nine (69%) states have experimented with several management initiatives in an effort to improve access to interagency services and supports for families. Table 11 illustrates the types of initiatives adopted.

Table 11

State Policy and Management Initiatives



N = 20

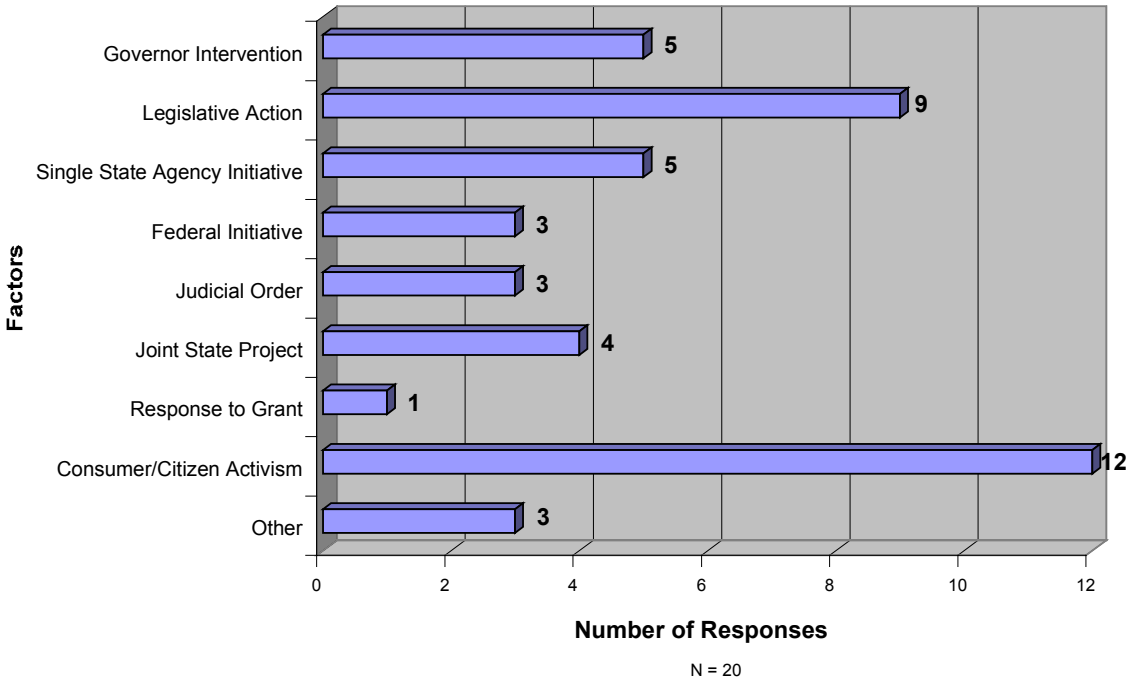
Eleven out of fourteen states (79%) reported that establishing a lead agency designation, creating a single point of entry, standardizing eligibility criteria and refining management information system technology significantly improved access to services and supports for individuals with mental retardation and developmental disabilities.

Influencing Factors

There is agreement among state and local agencies that reform is needed in order to improve coordination among the human service community. States have been struggling to develop such reform efforts and reported that there are a number of critical factors that influenced the development of these initiatives. Twenty out of twenty-nine states (69%) cited several factors. Table 12 illustrates that the most frequent response was consumer/citizen activism. States reported that in several instances, only a huge and potent groundswell of grassroots effort will move public officials to make meaningful reform. Drawing on the experience of states and communities that have been struggling with efforts to improve access, change begins with individuals, not institutions.

Table 12

Influencing Factors

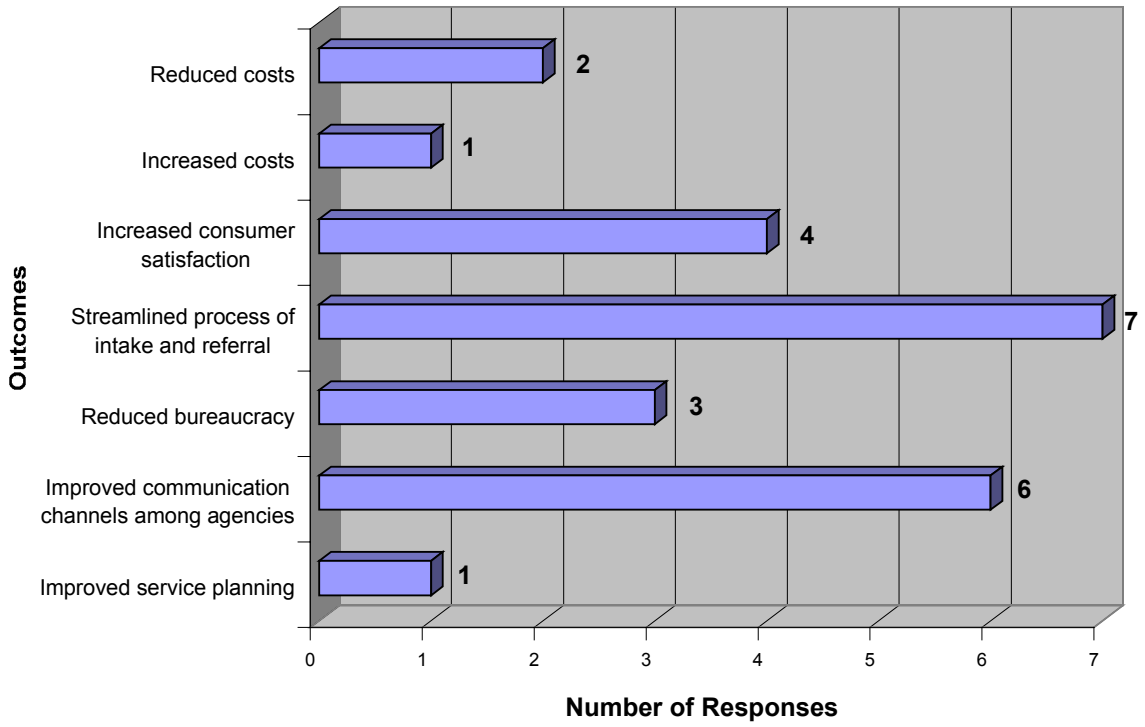


The final section of the survey asked participants to identify constructive outcomes and identify challenges and obstacles to implementing a single point of entry.

The current bureaucracy is fragmented which results in much duplication, waste, and inefficiencies which leads to confusion, serious inconvenience and ineffective service for consumers. At state and local levels there have been several initiatives and demonstrations to coordinate and integrate the various human service agencies particularly for high-risk populations. States expressed a consistent theme—a single point of entry will make it easier for families and individuals in need of supports to gain entry into the long-term care system. Eleven out of twenty-nine (38%) states have established a single point of entry within their system of care and have cited several positive outcomes. Table 13 illustrates that the two most widely acknowledged outcomes were improvements in communication channels among agencies and a streamlined process of intake and referral for individuals and families.

Table 13

Outcomes from Establishing Single Point of Entry



States have indicated that some aspects of community care systems can be tightly structured and uniform statewide without compromising their ability to flexibly respond to individual service needs. Uniform assessment tools, explicit financial eligibility criteria, and system entry channeled through case management agencies have all made access to community care more predictable from a consumer's perspective and more standardized as viewed by program administrators. When these three mechanisms are coordinated within a centralized system, individuals and families will not have to be subject to multiple screenings and assessments administered by different agencies, each of which may have a slightly different mandate or service orientation. This process also reduces inconsistencies in eligibility and functional assessments at all the various points of entry throughout a state. More consistent and coordinated screening for eligibility determination results in more equitable access for multiple populations. More consistent and coordinated functional assessments result in more efficient and appropriate provision of care.

Key components of a Single Point of Entry:

- ✓ Consumer assessment;
- ✓ Pre-admission screening;
- ✓ Case management.

Barriers to Implementation

An effectively designed single point of entry assumes that a solid foundation has been successfully laid for the operation of the single point of entry process. A key, and difficult task is the working out of uniform screening and assessment criteria among all involved parties that adequately account for the needs of multiple populations. In addition states espouse their own philosophical and programmatic goals dictated by dedicated funding or agency directives tailored to serve specific target populations. As a result, differing eligibility criteria and services often create much duplication as well as gaps in coverage. Twenty out of twenty-nine (69%) states reported that establishing a single point of entry involves resolving many difficulties and identifying barriers to implementation.

Barriers to Implementing a Single Point of Entry:

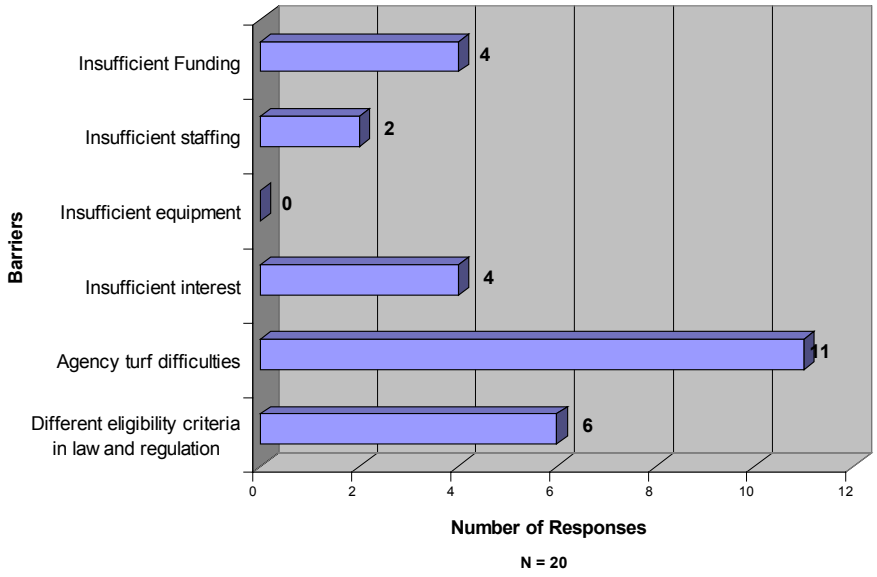
- Bureaucratic inertia;
- Funding constraints;
- Marketability and community outreach;
- Instability of political leadership;
- Management Information System integration;
- Staff training and evaluation;
- Consumer confidentiality and release of information.

(Texas Health and Human Services Commission, 2000)

Table 14 illustrates that the most significant barrier reported is "agency turf." The jurisdictional expansion engaged in by public agencies work against coordination. Turf wars are often caused or exacerbated by a lack of communication among agencies, which may generate misunderstanding and heighten unfounded suspicions. States that decided to implement a single point of entry had to invest significant time and resources to mitigate these issues.

Table 14

Barriers Preventing Single Point of Entry



Nearly all states mentioned the federal or state-legislated "silo" configuration of the various funding streams as an additional barrier. Coordinating service integration and access is difficult when the funding for various programs and services is tied to at least one of the following: age, income/assets, medical need/diagnosis, program-specific definitions, ceilings/capitations or geographic area.

Private/State/Federal Reform Initiatives

There is a growing body of data resulting from research conducted on programs in the various human services areas—in child welfare, health care, disabilities, and education that indicates the way we now deliver public human services is in need of reform. Policymakers, consumers, families, human services providers, advocates and program managers concur that the current system treats problems or concerns as isolated and individually based. As a result, specialized agencies have been established making it difficult to craft comprehensive solutions to complex problems. In addition, multiple programs, funding sources, intake and referral mechanisms and accounting rules generate wasteful duplication of services and administrative expenses.

Private Initiatives

Mindful of these concerns, many private, state and federal officials are considering new approaches that prospectively emphasize flexible standards, interagency strategies, coordination and cooperation in the delivery of services and supports. Particular attention is being focused on consolidation and service integration. The Annie E. Casey Foundation funds human services reform in seven states.

"Since the early 1990s, the foundation has recognized the need to move beyond single-system reform efforts, concluding that real and durable change will occur only when we help states, cities and neighborhoods begin to change multiple service systems simultaneously" (Annie E. Casey Foundation, Annual Report, 1998-1999).

Illinois was one of the initial states to receive funding from the Annie E. Foundation to participate in a sweeping reorganization of publicly funded human services. Core elements of this initiative include a state level collaborative and decision-making body (the Task Force) who were able to serve as a catalyst for state action, especially since they had strong support from the Governor and staff resources. They were able to craft interagency agreements with respect to the use of specific funding streams with little discord.

The Annie E. Casey Foundation

Jim Casey and his siblings, George, Harry and Marguerite established the Annie E. Casey Foundation in 1948. The foundations' first grant provided support to a camp for children deemed "at-risk" in Seattle, Washington. In 1999, their work was divided into three strategic themes: *Reforming Public Systems, Promoting Accountability and Innovation and Transforming Neighborhoods.* The grant payments exceeded $110 million in FY'1999.

State Initiatives

In July 1997, the *National Conference of State Legislatures* discussed the ideal long-term care system and developed a set of guiding principles and proposed several recommendations in order to "achieve a more rational continuum of care." Thirteen of the nineteen task forces addressed the issue of system fragmentation, agency consolidation, development of a "one-stop shopping" model, and implementation of a "no wrong door" approach in which people who come to the wrong place for information or assistance are directed to the right place. States agreed that the key goal of their proposed systems would be to coordinate services to facilitate easy access from one service to another.

Delaware consolidated its health and human services into a consolidated agency, the Department of Health and Social Services, in the early 1970s. The two major goals of this consolidated agency were to maximize consumer independence and create a structure, which allowed the organization to "fix its own problems." There was a commitment to "integrate programs and their funding sources while making it simple for individuals and families to access an ever more complex continuum of care" (Ooms and Owen, 1992). Local service centers were encouraged to be housed with private agencies whenever possible. These "one-stop" service centers have invested sufficient resources in centralized computerized data management systems and are quite effective.

In 1996, *Kentucky* launched one of the most extensive initiatives to "revamp and revitalize" the way in which citizens interacted with state government. Within the Empower Kentucky initiative, a primary technology initiative is the Simplified Access Project, targeted toward the improvement and integration of services to Commonwealth consumers. This project is a combined effort between the cabinets of various health and human service agencies and local community organizations across the state. This integrated service delivery effort has resulted in improvements in the way citizens gain access and information to state services, particularly those seeking job training and employment. "The creation of a single "data warehouse" has reduced administrative costs and increased consumers' ability to access programs and services through the system on their own" (American Management Systems, 2000).

Hawaii, is studying "the merits of establishing a single entry point for long-term care services used by elderly adults and families of disabled children and disabled younger adults" as directed by Senate Resolution No.33. The study recommended the establishment of a state interdepartmental coordinating council for the long-term care of older adults and individuals with disabilities. The council should include the Executive Office on Aging, the Department of Budget and Finance, the Department of Commerce and Consumer Affairs, the Department of Health, and the Department of Human Services. The guiding principle is "that better coordination will result in easier access for all clients…[and] improvements could include better coordination with agencies and providers, expanded use of technology for sharing information, standardized intake and/or referrals forms" (Hawaii Senate Resolution, 1995).

The *New York* Human Services Modernization Project combines the existing and separate information systems of human service agencies into a single statewide network of systems to support an integrated human service delivery system throughout the state. This new system supports a common intake process known as a "shared front-end" and will provide consumers with a consistent intake and referral experience regardless of the initial

agency they use to access the system. Integrating and managing all data and information regarding consumers, providers, programs and services is the primary goal of this initiative.

As experience with state collaborative efforts accumulates, various principles and procedures associated with successful collaboration are emerging as critical to their success and are being widely presented and disseminated.

Critical Success Factors:

- Ability to blend funds from multiple programs;
- Ability to invest in software tools and methodologies;
- Ability to support network infrastructure;
- Ability to hire new staff and provide sufficient training;
- Conduct ongoing review of legal and ethical issues associated with confidentiality.

(State of New York Human Services Modernization Project, 1999)

Federal Initiatives

Coordination and integration are often major themes that need to be embraced in federally sponsored initiatives.

The Child and Adolescent Service System Program (CASSP) instituted in 1984 developed and promoted a model for comprehensive, community-based systems of services for seriously troubled children. The CASSP funds granted to states have served as catalysts for many new initiatives at state and local levels to form interagency collaborations, which include joint planning, joint funding, cross-system training and centralized intake.

P.L.99-457, the Handicapped Infants and Toddlers program, provides funds to states "to develop and implement statewide, comprehensive, coordinated, multi-disciplinary, interagency programs of early intervention services for handicapped infants, toddlers, and their families." This program requires states to establish Interagency Coordination Councils, to assure that collaboration occurs between the numerous offices and bureaus that deliver services to this population at the state level.

The State Automated Child Welfare System (SACWIS) is a federally funded initiative enacted in 1993 to help states collect comprehensive information on all child welfare programs. Concerned about inadequate data regarding children in adoptions and foster care, Congress provided funds to ensure greater interagency coordination. SACWIS enables families and their children access to services from any point at which they enter the system. States have cited numerous benefits including improved coordination between agencies and easier access for families.

It is generally agreed that financing and reform at the state and federal levels greatly facilitated service integration initiatives.

Conclusion: Strategies for Improving Access

The human services delivery system for individuals and families is coming under increasingly critical scrutiny. Many are convinced that the basic design and organization of the present system of categorical services is ineffective, outdated and needs substantial reform. Services reform is especially urgent for those individuals and families who have multiple needs and require assistance from many public agencies. Families often experience monumental frustrations and barriers in accessing and securing appropriate supports. These "at risk" families often have between 4-6 workers assigned to them and have to maneuver through a maze of state offices.

Survey findings reveal many states (78%) are having difficulty facilitating interagency planning and are seeking strategies to improve coordination and collaboration. "Service integration" is the broad term that many states are now using to describe reform initiatives involving collaboration, coordination and system redirection. These reforms involve new processes of collaboration and partnership—across program sectors, between different levels of government, between private and public sectors and between providers and consumers.

A key component of service integration is the establishment of a single point of entry or "one-stop" shop where consumers could more easily obtain information and access to services. Survey findings indicate that several states (38%) have created a single point of entry and noted significant improvements in communication with sister agencies and a streamlined process of intake and referral for consumers. Creating a single point of entry implies a shift in policy away from a categorical approach toward a generic approach based on individuals' common functional limitations. A single point of entry involves the coordination or consolidation of screening, assessment and case management. Consumers would not have to complete multiple screenings and assessments and would be directed to the right place for assistance and supports. This system has reduced duplication and confusion for families and increased efficiency and productivity for administrators and providers.

It is important to remember that a single point of entry is only one component of a long-term care system and implementation requires a major investment of time and resources. Drawing on the experience of states and communities that have implemented a single point of entry, states will have to address at least four specific issues to be able to ensure successful integration.

First, states will need to *revise governance structures so they will support service integration and the development of a single point of entry.* These include new legislative and executive branch structures, and most important local governance entities. Linkages need to be established between the various disability agencies given that many do not have much experience working together at any level—from service coordination, to regional planning, to state level policymaking. States have been experimenting with new executive branch structures to see if these can be more effective than the traditional separate, multiagency approach. Survey findings indicate that nine states have consolidated multiple state agencies in order to counter fragmentation and are pleased with the results.

Second, states need to invest in *developing and implementing effective management information systems* that provide policymakers and administrators with the outcome data needed to make policy and program decisions, provide supervisors with the information they need to make appropriate case loads, and provide front-line workers with the technology to reduce paperwork while simultaneously facilitating service integration. This is perhaps the most difficult challenge facing states in supporting integrated local access due to the complexity and cost factors. It is complex because any information system should be consistent across the state while at the same time meeting local needs and allowing for local control. It is costly because many states will have to invest additional funds to support advanced technology efforts.

Third, states will need to *adopt a variety of financing strategies*. They need to combine sufficient funds from different sources to be able to sustain comprehensive, integrated service provision. States will need to develop funding that is flexible and can meet service needs that do not fit into pre-formed categorical packages. Funding strategies that states have experimented with include the redeployment of funds into pooled, flexible dollars which can be used to fund integrated service delivery, private foundation and federal grants involved in the implementation of a "one-stop" shopping model and increased federal financial participation for integrated development strategies.

Finally, states will need to *invest in training, technical assistance, new technologies, and service/program evaluation.* The current public human services workforce cannot be expected to move from a system that stresses categorical eligibility and rigid policies and procedures to one that focuses on generic categories and streamlined uniform assessments without training and support. States will need to provide both state agencies and local offices technical assistance necessary to plan and implement these new structures. Integral to the success of this initiative is the willingness of all stakeholders to cooperate and collaborate and provide ongoing feedback.

Creating this new enterprise is not an easy venture. It requires rethinking the mechanisms which states have developed in the past. If our service delivery systems were created to meet the needs of the people then they have to be more user-friendly. An effective single point of entry is based on the assumption of shared responsibility for individuals and families, which cuts across traditional professional, organizational and bureaucratic boundaries.

Our study has revealed that some aspects of community care systems can be tightly structured and uniform statewide without compromising their ability to flexibly respond to individual service needs.

It is incumbent upon all stakeholders to support systemic improvements and refocus their energies on areas that are in need of review. The challenge is to continue to explore strategies and avenues to address system flaws and design a system that is responsive to all families in need of support.

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Appendix 1

Governor's Commission on Mental Retardation
One Ashburton Place
Room 805
Boston Ma 02108

Single Point of Entry

Survey

February 2001

PLEASE RETURN THE SURVEY BY FEBRUARY 9, 2001
USING THE ENCLOSED POSTAGE-PAID ENVELOPE

Governor's Commission on Mental Retardation

One Ashburton Place, Room 805
Boston, MA 02108
Phone: (617) 727-0517 Fax: (617) 727-0887

ID#____

Single Point of Entry
Survey

The first set of questions relates to demographic information.

1. Please indicate the number of individuals with *developmental disabilities* who currently receive services in your state. (FY'99) _____

2. Please indicate the number of individuals with *mental retardation* who currently receive services in your state. (FY'99) _____

3. What is the general population of your state? (FY'99) _____

The next set of questions relates to the Federal Home and Community Based Waiver Program.

4. Does your state participate in the Federal Home and Community Based Waiver Program?

_____ Yes

_____ No (If no, skip to question 5.)

4a. What year did your state start participating in the Federal Home and Community Based Waiver program?_____

4b. How many individuals with *mental retardation* are currently receiving waiver services? (Actual provision) _____

4c. How many slots are approved for individuals with *mental retardation* in the waiver program? (Approved/ services pending) _____

4d. What are the current waiver expenditures for individuals with *mental retardation* in your state? (FY'99) $_____

4e. How many individuals with *developmental disabilities* are currently receiving waiver services? (Actual provision) _____

4f. How many slots are approved for individuals with *developmental disabilities* in the waiver program? (Approved/services pending) _____

4g. What are the current waiver expenditures for individuals with *developmental disabilities* in your state? (FY'99) $_____

The next set of questions relates to state agency structure.

5. Please indicate which model most closely describes your current organizational structure.

_____***Consolidation Model (****All long term care responsibilities covering both institutional and community based care for individuals with mental retardation and other developmental disabilities are consolidated into a single sole purpose agency. All long term care expenditures for MR/DD are placed in one budget.)*

_____***Umbrella Agency Model (****Utilizes a human service agency structure with separate cabinet agencies reporting to a human service secretariat. Services and supports for individuals with mental retardation and other developmental disabilities are managed within the separate cabinets with oversight from the human service agency.)*

_____***Cabinet Agencies Model*** *(Retains independent cabinet level agencies responsible for providing services and supports to individuals with mental retardation and other developmental disabilities. Agencies report directly to the executive branch of state government for oversight.)*

_____*Other (please describe)*_____
_____
_____
_____

6. Does your state have a current organizational chart that describes the agencies responsible for the delivery of services and supports for individuals with mental retardation and other developmental disabilities?

_____ Yes (Please include a copy with your completed survey.)

_____ No

7. What agency/agencies are responsible for the delivery of services and supports for individuals with mental retardation and developmental disabilities?
_____
_____
_____

The next set of questions relates to state financing strategies.

8. What financing strategy is utilized to provide services and supports to individuals with mental retardation and developmental disabilities? *(Please indicate the strategy and the percentage of total budgetary dollars attributed to this method.) (Check all that apply)*

_____ State-generated funds _____%
_____ Medicaid home and community based waivers ___%
_____ Other (Please explain) _____ %_____

9. What financial management system most closely resembles your state structure?

_____A state government operated financing system with direct state-provider dealings.
_____A mixed state government/local government financial management system.
_____A fully local system with state funds block- granted to localities.
____ Other (please explain)_____

The next set of questions relates to state agency program management.

10. Has your state experienced difficulties in facilitating access to interagency services and supports for individuals with mental retardation or developmental disabilities?

_____Yes

_____No (If no, skip to question 11)

10a. Has your state implemented any policy and management initiatives in order to improve access to interagency services and supports for individuals with mental retardation or developmental disabilities?

____Yes

____No (If no, skip to question 11)

10b. Please select which policy and management initiatives your state has implemented in order to improve access to interagency services and supports. *(Please check all that apply.)*

_____Established lead agency designation
_____Designed standardized intake tool
_____Designed standardized eligibility criteria
_____Improved management information system technology
_____Assigned a centralized case manager
_____Established a single point of entry
_____Revised resource allocation methodologies
_____Revised financial eligibility guidelines
_____Established uniform access criteria
_____Developed standardized client assessment tools
_____Other *(Please explain*)_____
_____
_____

10c. Please indicate the level of effectivess of policy and management initiatives regarding access to interagency services and supports for individuals with mental retardation and developmental disabilities. *(Please check off the category that applies.)*

Policy and Management Initiative	**Not effective**	**Minimal Improvements 1-25%**	**Adequate Improvements 26-50%**	**Significant Improvements 51% or greater**
Established lead agency designation				
Designed standardized intake tool				
Designed standardized eligibility criteria				
Improved management information system technology				
Assigned a centralized case manager				
Established a single point of entry				
Revised resource allocation methodologies				
Revised financial eligibility guidelines				
Established uniform access criteria				
Developed standardized client assessment tool				

10d. Please indicate which factor (s) shaped the policy and management initiatives that occurred in your state. *(Please check all that apply.)*

_____Governor Intervention
_____Legislative Action
_____Single State Agency Initiative
_____Federal Initiative
_____Judicial Order
_____Joint State Project
_____Response to Grant
_____Consumer/Citizen Activism
_____Other (please explain) _____
_____
_____

The next set of questions relates to intake and referral activities for services and supports.

11. Which screening/intake system most closely resembles your state structure? *(Screening and intake includes reviewing the individual's/family's needs, eligibility determinations, providing program information and making potential referrals.)*

___ Screening/Intake activities are administered individually by separate state agencies.
___ Screening/Intake activities are administered by a centralized reporting authority.
___ Screening/Intake activities are administered by a local or county authority.
___ Screening/Intake activities are administered by a regional authority.
___ Screening/Intake activities are administered by provider agencies.
___ Other (Please explain) _____
_____
_____

12. Which referral system most closely resembles your state structure? *(Referral includes scheduling contacts, reviewing available resources, determining resource availability and establishing service linkages.)*

____ Referral activities are administered individually by separate state agencies
____ Referral activities are administered by a centralized reporting authority
____ Referral activities are administered by a local or county authority
____ Referral activities are administered by a regional authority
____ Referral activities are administered by provider agencies
____ Other (Please explain)_____
_____
_____

This next set of questions relates to the establishment of a single point of entry.

13. Has your state established a single point of entry for individuals with mental retardation or developmental disabilities who require interagency services and supports? *(Single point of entry refers to standardized intake and referral information organized around the consumer. Individuals and families can experience successful intake and receive information at any portal in the state system irrespective of a specific agency's eligibility requirements.)*

_____Yes
_____No (If no, skip to question 13c.)

13a. If yes, what outcomes have resulted from establishing a single point of entry into the service system? (Please check all that apply.)

_____Reduced costs
_____Increased costs
_____Increased consumer satisfaction
_____Streamlined process of intake and referral
_____Reduced bureaucracy
_____Improved communication channels among agencies
_____Other (Please explain) _____

13b. If yes, is there a written plan that describes the single point of entry process?

_____Yes (please submit a copy of the document)
_____No

13c. If no, what barriers have prevented your state from developing a single point of entry? (Please check all that apply.)

____ Insufficient funding
____ Insufficient staffing
____ Insufficient equipment
____ Insufficient interest
____Agency turf difficulties
____Other (Please explain) _____

This last set of questions relates to the general status of your service delivery system for individuals with mental retardation or developmental disabilities.

14. What compliment is heard most often about your service delivery system for individuals with mental retardation or developmental disabilities?

_____
_____
_____

15. What complaint is heard most often about your service delivery system for individuals with mental retardation or developmental disabilities

_____
_____
_____

16. What actions do you think need to be taken on a national level to further enhance access to interagency services and supports for individuals with mental retardation or developmental disabilities?

_____
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Thank you for completing this survey. Please mail your response in the enclosed envelope. You may also fax your response to (617) 727-0887.